

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

06290

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:

County.....*St. Marys*City or town.....*Mechanicsville Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*Life*

Hospital, Institution, or street address where death occurred:

Mechanicsville, Md

How long in hospital or institution?.....

3. (a) FULL NAME

Horace Hunt Bowling

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male white married*6. (b) Name of husband or wife.....*Helena Joy Bowling*

7. Birth date of deceased (mo., day, yr.)

Aug - 12 - 1886

6. (c) If alive, give age

years

8. AGE:

Years	Months	Days	If less than one day
<i>59</i>	<i>11</i>	<i>16</i>	hrs. min.

9. Birthplace *Bryantown Charles Maryland*
(Town, county, and state)10. Usual occupation.....*Salesman & Farmer*

11. Industry or business

12. Name.....*Aloysius E. Bowling*13. Birthplace *Charles Co*14. Maiden name *Mary C. Hunt*15. Birthplace *Frederick George Co*16. Informant *Horace X. Bowling Jr*Address *Mechanicsville Maryland*17. Burial *Funeral* Date thereof *July 31 1947*
(Burial, cremation, or removal. Which?)Cemetery or crematory *St Aloysius Cemetery*Location *Leonardtown Maryland*18. Funeral director *W. C. Mattingley Sons*Address *Leonardtown Maryland*19. *7/31 1947* Cremated

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*St. Marys Co*City or town.....*Mechanicsville*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216-12-4710

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Tues 8 1947 to Tues July 27 1947*and that I last saw h. *5:20* alive on *July 27* *1947*Immediate cause of death.....*Cancerous*

DURATION

Due to.....*Cancerous* Right kidney *(27/47)*Due to.....*Cancerous*Other conditions.....*Cancerous*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. D. Chapman

M. D. or other

Address.....*Frederick 100* Date signed *7/29/47*



06291



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death?..... Hospital, institution, or street address where death occurred:.....				
How long in hospital or institution?.....				
3. (a) FULL NAME <i>Infant female</i>				
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Female	colored	single		
6. (b) Name of husband or wife.....				
7. Birth date of deceased (mo., day, yr.) <i>July 5 - 1947</i>				
6. (c) If alive, give age years				
8. AGE:	Years	Months	Days	It less than one day
			2	hrs. min.
9. Birthplace..... (Town, county, and state) <i>Oakville St. Mary's Maryland</i>				
10. Usual occupation..... <i>Infant</i>				
11. Industry or business.....				
FATHER	12. Name..... <i>James Melvin Coats</i>			
MOTHER	13. Birthplace..... <i>St. Mary's Co</i>			
	14. Maiden name..... <i>Pauline Chase</i>			
	15. Birthplace..... <i>St. Mary's Co</i>			
16. Informant..... Address..... <i>James M. Coats Mechanicsville MD</i>				
17. Burial, cremation, or removal. Which?..... Date thereof..... (month) (day) (year) <i>Burial July 7-1947</i>				
Cemetery or crematory..... <i>On premises</i>				
Location..... <i>near Oakville</i>				
18. Funeral director..... Address..... <i>J.W. & W. Mattingly Sons Lincroft New Jersey</i>				
19. Date rec'd by registrar..... 19..... (Date rec'd by registrar)..... <i>7/7 1947</i>				

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

282

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
Maryland County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
Mechanicsville Rd. # 071
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
*July 7 1947*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19.....
*on July 7th 1947*and that I last saw h..... alive on.....
*19*Immediate cause of death.....
Suffocation

DURATION

Due to.....
*Head Cold and
accidental drowning*Due to.....
*sleeping in box
with Mother*

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....
James M. Coats

M. D. or other

Address.....
James M. Coats Date signed *7-3-47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No.

06292
256

1. PLACE OF DEATH:
 County *Spangler's*
 City or town *Broad Avenue*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *33 yrs*
 Hospital, Institution, or street address where death occurred
 How long in hospital or institution?

3. (a) FULL NAME

George Robert Dyer

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<i>m</i>	<i>col</i>	<i>widowed</i>

6. (b) Name of husband or wife *Jane Louise Dyer*

7. Birth date of deceased (mo., day, yr.) *Sept 0 - 1888*

6. (c) If alive, give age years

8. AGE: Years *69* Months *11* Days *10* If less than one day

9. Birthplace *Broad Avenue, Spangler's*
 (Town, county, and state)

10. Usual occupation *By definition*

11. Industry or business *Business*

MOTHER FATHER

12. Name *Richard Henry Dyer*

13. Birthplace *Broad Avenue, Spangler's*

14. Maiden name *Mary Elizabeth Dyer*

15. Birthplace *Broad Avenue, Spangler's*

16. Informant *Charles Henry Dyer*

Address *Spangler's*

17. Burial *Buried* Date thereof *5-17-77*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Spangler's*

Location *Broad Avenue, Spangler's*

18. Funeral director *W.C. Walker & Son*

Address *In addition*

19. *2-30-77* *1977* M.V. *17*

(Date rec'd by registrar) (Year) (Month) (Day)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State *Md* County *St. Mary's*
 City or town *Broad Avenue, Spangler's*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *7-30-47* 1947 at *3 a.m.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-15- 1947 to *7-30* 1947

and that I last saw h. alive on *7-29* 1947

Immediate cause of death

Pneumonia
septicemia

Due to

Second stage of pneumonia

Other conditions existing deceased

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Robert V. Palmer* M. D. or other

Address *Acme* Date signed *2-30-77*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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06293

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Eliza Gisard

4. Sex

M

5. Color of face

col

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Sally Walter

7. Birth date of

deceased (mo., day, yr.)

August 10

6.(c) If alive, give age

years

8. AGE:

Years
41

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

St. Charles

(Town, county, and state)

10. Usual occupation.....

Teacher

11. Industry or business

on farm

12. Name.....

M. F. R.

13. Birthplace

St. Charles

14. Maiden name.....

Eliza Gisard

15. Birthplace

St. Charles

16. Informant.....

Charlotte Palmer

Address

Carolineton Da

17. (Burial, cremation, or removal? Which?)

Buried

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Baptist Cemetery

Location

St. Marys

18. Funeral director.....

Elmer M. Day

Address

Hagerstown Md

19. (Date rec'd by registrar)

7/3/47

Cause of death.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

St. Marys

City or town.....

(St. Marys) Charlotte, Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

—

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

7-2nd 1947 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Received deceased on July 31, 1947

and that I last saw her alive on 19.....

Immediate cause of death.....

Pneumonia

DURATION

Cause of death.....

Inflammation of lower lobes

Due to.....

Inflammation

Cause of death.....

Having chest opened

DURATION

Cause of death.....

Between factor and product

Other conditions.....

Some burning of breast

DURATION

Cause of death.....

of breast on side & right

DURATION

(Include pregnancy within 3 months of death)

which would be very

Major findings of operations.....

on the case

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Accident Date of

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

On duty

Means of injury.....

Crushed between

DURATION

and at work?

Die

23. SIGNATURE.....

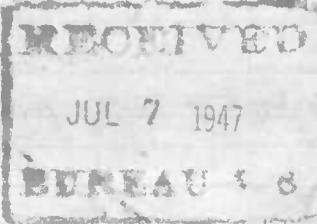
F. J. Gisselwehr

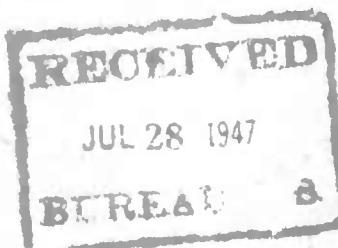
M. D. or other

Address.....

7-3-1947

DURATION





N PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

IEvidence for charges
made shown as:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06295

File No: G 110 JUL 22 1947

83a CB
282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... St. Marys

City or town..... Tall Timbers

(If outside city or town limits, write RURAL and give nearest town)

2 months

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah P. Keleher

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

April 30, 1866

... (c) If alive, give age..... years

8. AGE: Years

67

Months

8

Days

2

If less than one day

hrs.

min.

9. Birthplace..... Washington, D.C.

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name..... William F. Keleher

Pettie

13. Birthplace..... Baltimore, Maryland

14. Maiden name..... Sarah Lemon

15. Birthplace..... Salem, Massachusetts

16. Informant..... Mrs. Florence Petty - Srs T. Keleher

Address..... 4774- 25th N. Arlington, Va.

17. Transportation..... Date thereof..... 7/17/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington, D.C.

18. Funeral director..... P.B. Robinson

Address..... Leonardtown, Maryland.

19. Date rec'd by registrar..... 7/17/47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... New Jersey

County.....

Red Bank

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 15

19 47 at 6:25P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1947, to July 15, 1947

and that I last saw her alive on July 15, 1947

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

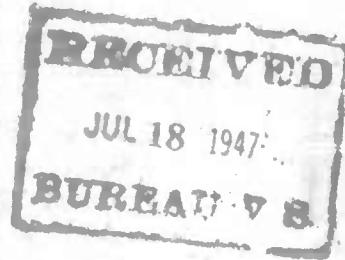
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed..... 7/17/47



06296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 281

92d

~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.~~

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

1. PLACE OF DEATH:

County.....

St. Mary's

City or town.....

Ridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death..... 6.3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William S. Raleigh

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife.....

Estelle Raleigh

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

Aug. 11 1871

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Chesterstown Md.

(Town, county, and state)

10. Usual occupation.....

Justice of Peace

11. Industry or business.....

MOTHER FATHER

S. L. Raleigh

13. Birthplace

Chesterstown Md.

14. Maiden name

Mary Booth

15. Birthplace

St. Mary's Co., Md.

16. Informant.....

James B. Raleigh

Address.....

Ridge Md.

17. Burial

Date thereof..... 8-2-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. Michaels Cemetery

Location.....

Ridge Md.

18. Funeral director.....

W. C. Mattingly Sons

Address.....

Leonardtown Md.

19. Date rec'd by registrar.....

1947

P. O. Box No. _____

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Mary's

City or town..... Ridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30 1947 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to July 30 1947

and that I last saw him alive on July 30 1947

Immediate cause of death..... Chronic & valvular heart disease

DURATION

8 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. O. Box No. _____

M. D. or other

Address..... Great Mills, Md. Date signed..... 8-1-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06297

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County

St. Marys

City or town

Mechanicsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

one year

Hospital, institution, or street address where death occurred

Mechanicsville R. F. D. # 2 MD

How long in hospital or institution?

3. (a) FULL NAME

John Walter Lippett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife

Ethel Lippett

7. Birth date of deceased (mo. day, yr.)

6.(c) If alive, give age

years

Nov - 12 - 1858

8. AGE: Years Months Days If less than one day

88 8 19 hrs. min.

9. Birthplace

(Town, county, and state)

Prince George Co Md

10. Usual occupation

Farmer

11. Industry or business

Milkman

MOTHER FATHER

12. Name

Unknown

13. Birthplace

—

14. Maiden name

Unknown

15. Birthplace

—

16. Informant

Mrs Douglas Morgan

Address

Mechanicsville R. F. D. # 2 MD

17. Burial Date thereof

Aug 2 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Joseph Cemetery

Location

Moersch Maryland

18. Funeral director

W C Mattingley Sons

Address

Leonardtown MD

19. Aug 1 1947 Cleaver S. Carter

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County St. Marys

City or town

R. F. D. # 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Mechanicsville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31 1947 al 1245 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

See 1947 to July 31 1947

and that I last saw him alive on

Immediate cause of death

Mental derangement

Due to

Due to

Other conditions

old age

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

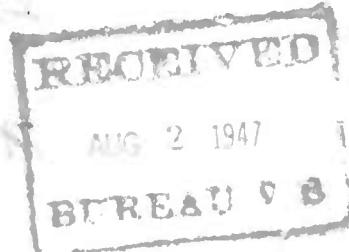
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Levin J. Sosik

M. D. certif.

Address Leacock Hall Date signed 8/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No.

06298
282

1. PLACE OF DEATH:

County.....

St. Mary's

City or town... Lexington Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Welch

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male colored single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

August 7 1923

8. AGE:

Years
23

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Georgia

(Town, county, and state)

10. Usual occupation.....

labor

11. Industry or business.....

Vesie Welch

FATHER

12. Name.....

Georgia

13. Birthplace.....

Alberta Walker

14. Maiden name.....

Georgia

15. Birthplace.....

Vesie Welch

16. Informant.....

29 - Devere St. NW Wash. D.C.

Address

Transportation

Date thereof.....
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Location.....

Midville, Georgia

18. Funeral director.....

P.B. Robinson

Address.....

Leonardtown

19. Date rec'd by registrar.....

7/8/47

19. Date signed.....

canalier

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Mary's

City or town... Lexington Park Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 7 1947 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from named deceased on July 7 1947 and that I last saw h..... alive on Hospital 19.....

Immediate cause of death..... Pneumonia DURATION Throat 40 min.

Due to..... Death occurred

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... homicide Date of 7/7/47

Where did injury occur? Lexington St. St. Mary's Md. (City/town) (County) (State)

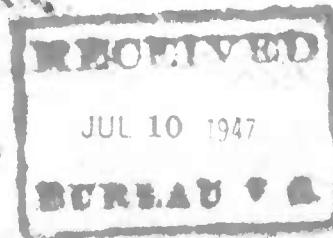
Injured at home, farm, industry, public place (where?) public place

Means of injury gun shot Injured at work? no

23. SIGNATURE..... Francis F. Greenwell M.D.

M. D. or other

Address..... Leonardtown Date signed 7/8/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH 73d

2411 N. Charles St., Baltimore

06299

Reg. Diat. No. 28

Form No. 6 116 MAY 24 1948

CERTIFICATE OF DEATH

CB

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles C. White

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Evelyn St. Clair White

7. Birth date of deceased (mo. day yr.)

April 13 1887

6. (c) If alive, give age 46 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

4/18 65 3 10

9. Birthplace

U.S. District of Columbia

(Town, county, and state)

10. Usual occupation

Retired business man

11. Industry or business

William White

MOTHER FATHER

12. Name

William White

13. Birthplace

Washington D.C.

14. Maiden name

Mary E. Lyons

15. Birthplace

Washington D.C.

16. Informant

Evelyn St. Clair White

Address

1341 Ridge Place, S.E.

17. Burial

Date thereof July 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Washington D.C.

18. Funeral director

W.C. Maitland, Son

Address

Leonardtown Md.

19. Date rec'd by registrar

1/23 47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 1341 Ridge Place S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
I saw deceased on July 19, 1947, on July 23, 1947,

and that I last saw him alive on

Immediate cause of death. Cardiac vascular disease

Due to. unknown

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

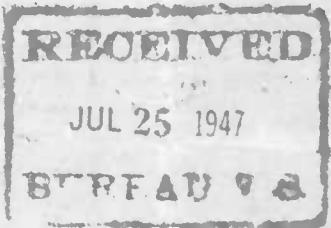
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Leonardtown Md. Date signed January



3 - 10 - 8
1881 - 22 - 1
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06300

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH CB

Reg. Date No. 282

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry J Williams

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife

Mable M Williams

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

May 25 - 1891

8. AGE:

Years Months Days If less than one day
56 1 20 hrs. min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Frederick J Williams

MOTHER FATHER

12. Name

Washington D.C.

13. Birthplace

Elle M Lassby

14. Maiden name

Maryland

15. Birthplace

Frederick J Williams

16. Informant

Address

709-729 10 S.E. Washington D.C.

17. Burial

Date thereof

July 18-1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Hill Cemetery

Location

Washington D.C.

18. Funeral director

W.C. Mattingly Sons

Address

Leonardtown Md

19.

7/16 47

Cause of death

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 16 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sauro charred on July 16, 1947

and that I last saw h... alive on

Immediate cause of death

Cardio circulatory disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

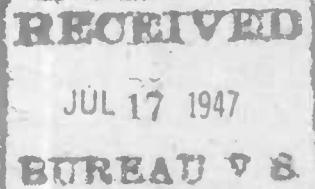
23. SIGNATURE

Francis F Gaumer M.D.

M. D. of other

Address

Leonardtown Md Date signed 7-16-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, give age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06301

93d

CERTIFICATE OF DEATH

Reg. Distr. No. 282

1. PLACE OF DEATH:

County

St. Marys

City or town

Helen Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Helen Maryland

How long in hospital or institution?

3. (a) FULL NAME

Mollie Wheeler Young

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female colored widow*6. (b) Name of husband or wife *Stephen H. Young*7. Birth date of deceased (mo., day, yr.) *1861*8. AGE: Years *86* Months *0* Days *0* If less than one day *0* hrs. *0* min. *0*9. Birthplace *MD* (Town, county, and state)10. Usual occupation *At home*

11. Industry or business

12. Name *Uncle*

13. Birthplace

14. Maiden name *Eliza Celia Wheeler*15. Birthplace *MD*16. Informant *Mary Recal*Address *Helen Maryland*17. Burial Date thereof *July 29, 1947*
(Burial, cremation, or removal. Which?) *Burial* (month) *July* (day) *29* (year) *1947*Cemetery or crematory *St. Joseph Cemetery*Location *Maryland*18. Funeral director *W. C. Mattinley Sons*Address *Lewistown MD*19. Date rec'd by registrar *7/28/47* 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *St. Marys*City or town *Helen* (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 27* 1947 at *2:35 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July 26* 1947 to *July 27* 1947 and that I last saw her alive on *July 27* 1947.Immediate cause of death *Bronchitis Myocarditis*

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *P.B. Johnson*M. D. or other _____ Date signed *7/27/47*Address *Maryland*

